BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF: **TERESA BORCHERS, D.O.** Holder of License No. **3681** For the practice of osteopathic medicine in the State of Arizona	**Case No.: DO-14-0279A** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER FOR ADMINISTRATIVE WARNING**

On October 30, 2014, the Arizona Board of Osteopathic Examiners (hereafter "Board") received a complaint against Teresa Borchers, D.O. (hereafter "Respondent"). On October 30, 2014, the Board noticed Respondent of an investigation into that complaint.

On September 8, 2015, the Board invited Respondent to attend an Investigative Hearing on this matter. The initial review was set for November 21, 2015 but a continuance was requested and it was set for January 23, 2016. After additional investigation the Investigative Hearing was continued on January 21, 2017. Respondent was present, participated in the Investigative Hearing and appeared with counsel, Kenneth Gregory.

After hearing testimony from Respondent and considering the documents and evidence submitted, the Board voted to enter the following Findings of Fact, Conclusions of Law, and Order for Administrative Warning.

JURISDICTIONAL STATEMENTS

1. The Board is empowered, pursuant to A.R.S. § 32-1800 et seq., to regulate the practice of osteopathic medicine in the State of Arizona, and the conduct of the persons licensed, registered, or permitted to practice osteopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 3681 issued by the Board for the practice of osteopathic medicine in the State of Arizona.

FINDINGS OF FACT

3. On October 30, 2014, V.M. filed a complaint with the Board alleging that Respondent treated her since September 2013 for diabetes and the care was inadequate.

4. On August 22, 2013, V.M., a 44 year old female, began treatment with Respondent for chief complaints of hot flashes, vaginal dryness and night sweats. Respondent documented V.M.'s history and performed a physical examination. Respondent's assessment of V.M. indicated "Hypothyroidism, Acquired 244.9 and Vasomotor 627.2. Respondent ordered blood work. Respondent's initial instructions for V.M. included annual mammograms, continue self-examination of breasts, annual Pap smears and increase exercise.

5. At her initial visit, V.M. reported a history of hypertension and cardiac surgery as a child. There is no indication in Respondent's medical records for V.M. that V.M. had a previous EKG or that Respondent ordered an EKG for V.M. given her history.

6. V.M.'s next appointment with Respondent was on September 5, 2013 to review the results of the lab tests. At this appointment, Respondent diagnosed V.M. with type II, uncontrolled diabetes, hypothyroidism and vasomotor. According to a medication log, Respondent prescribed V.M. Glucovance to treat her diabetes. Respondent, however, did not document the medication in the progress notes in V.M.'s medical record until the next visit.

7. The standard of care for the diagnosis and treatment of diabetes requires a physician to include the following: a comprehensive history from the patient that includes eating patterns, physical activity, identification of common comorbidities, a review of any previous treatments or workups done and a review of any history of diabetes-related complications; a physical exam that includes a routine physical exam, a funduscopic exam, thyroid palpation, a skin exam, and a comprehensive foot exam; referral the patient for diabetic education (or provide education directly to ensure the patient understands their role in the management of the diabetes), annual eye examinations and a dental examination. Respondent

deviated from the standard of care by failing to perform a thorough history or a thorough physical exam early in V.M.'s care, failing to refer V.M. for diabetic education or, alternatively, providing the education to V.M., and failing to refer V.M. for an eye, dental or podiatric exams.

8. On January 7, 2014, V.M. presented to Respondent for lab results from blood work done at an earlier appointment. V.M. complained of ear pain, sore throat, cough and chest pain. There is no indication in V.M.'s medical record that Respondent performed any cardiac work-up, including an EKG in response to V.M.'s complaint of chest pain.

9. Between January 7, 2014 and August 18, 2014, Respondent saw V.M. multiple times for complaints ranging from urinary tract infection, upper respiratory infection, and reactions to medications. It is unclear from V.M.'s medical records if Respondent performed a physical examination at each of V.M.'s visits as the exams documented were a template of a normal complete history and physical with a review of systems and a well woman exam at each visit. The recommendation and plan were the same for each visit regardless of the chief complaint.

10. In July 2014, V.M. returned with urinary symptoms and blood sugars running in the 250-300 range. Respondent started V.M. on Victoza and treated her for a urinary tract infection even though the urinalysis was normal other than 3+ glucose. The patient had been noncompliant with the Glucovance. On September 2, 2014, V.M. was admitted to the hospital with shortness of breath. She was discharged on September 5, 2014, with the diagnoses of an acute non-ST elevation myocardial infarction, acute chronic obstructive pulmonary disease exacerbation, hypo-magnesemia, tobacco abuse disorder, diabetes type II uncontrolled, dyslipidemia, hypothyroidism, congenital heart disease, status post repair.

11. On September 10, 2014, an employee of Respondent's clinic documented that she spoke with V.M. telephonically and advised her that Respondent would no longer see her

as a patient. There is no indication in V.M.'s medical records that Respondent sent a discharge letter to Respondent, as required.

12. Respondent failed to adequately document each of V.M.'s office visits. The physical exams were documented as a normal well-woman exam, including a review of systems, at the time of each visit using the same template each time. It is unclear what, if any, physical exam Respondent actually performed at each visit. Additionally, Respondent failed to document any discussions regarding V.M.'s chief complaints or physical examination changes specific to each visit. Respondent's documented recommendations and treatment plans were the same for each visit using the same template each time.

13. Respondent failed to properly document in V.M.'s medical records the medications prescribed for each visit. The medications were not documented in the progress notes until the V.M.'s subsequent visit when Respondent added the medications to the medication list. This does not allow a subsequent provider to easily determine what medications Respondent prescribed at each visit. Respondent documented medications prescribed in the medication log but not in V.M,'s progress notes. Additionally, Respondent did not maintain a current medication list for V.M. Medications that were no longer prescribed remained on the medication list in V.M.'s medical records. This does not allow a subsequent provider to easily determine what medications were discontinued and when they were discontinued.

14. During the Board's investigation of Case No. DO-14-0279A, Respondent claimed the initial response to the complaint submitted to the Board was a forgery and she did not submit it. In addition, she reported the records had been modified or altered.

15. The Board took this information into consideration but found Respondent's medical care of V.M. to be below the standard of care.

CONCLUSIONS OF LAW

16. The conduct described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1854 (6), which states "Engaging in the practice of medicine in a manner that harms or may harm a patient or that the board determines falls below the community standard."

17. The conduct described above constitutes unprofessional conduct pursuant to A.R.S. §32-1854 (36), which states "Prescribing or dispensing controlled substances or prescription-only medications without establishing and maintaining adequate patient records."

18. The conduct described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1854 (38), which states "Any conduct or practice that endangers the public's health or may reasonably be expected to do so."

ORDER

Pursuant to the authority vested in the Board,

IT IS HEREBY ORDERED that Respondent, Teresa Borchers, D.O, holder of osteopathic medical License number 3681, is issued an Administrative Warning.

1. **IT IS HEREBY FURTHER ORDERED** that Respondent, Teresa Borchers, D.O., holder of osteopathic medical License number 3681, shall complete sixty (60) hours of Continuing Medical Education ("CME") on or before December 31, 2017 in the following areas: 20 CME hours in diabetic management; 10 CME hours in endocrine management; 10 CME hours in medical record keeping; and 20 CME hours in cardiology. Respondent shall provide Board staff with satisfactory proof of completion of the required CME on or before January 30, 2018. The CME hours **must be approved in advance** by the Board's Executive Director, and shall be in addition to the hours required for biennial renewal of Respondent's osteopathic medical license.

2. **Costs:** Respondent shall bear all costs incurred regarding compliance with this Order.

3. **Obey All Laws:** Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in the State of Arizona.

4. **Ceasing Practice in the State of Arizona:** In the event that Respondent ceases to practice medicine in the State of Arizona, by moving out of state, failing to renew her license, or maintaining an Arizona license but ceasing to practice clinical medicine or administrative medicine requiring licensure, Respondent shall notify the Board that she has ceased practicing in Arizona, in writing, within 10 days of ceasing to practice. In its sole discretion, the Board may stay the terms of this Order until such time as the Respondent resumes the practice of medicine in Arizona, or may take other action to resolve the findings of fact and conclusions of law contained in this Order.

5. **Failure to Comply / Violation**: Respondent's failure to comply with the requirements of this Order shall constitute an allegation of unprofessional conduct as defined at A.R.S. § 32-1854(25) and proven violations may be grounds for further disciplinary action (e.g., suspension or revocation of license).

ISSUED THIS 7th DAY OF FEBRUARY, 2017.
ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
IN MEDICINE AND SURGERY

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS SEAL

By: _____
Jenna Jones, Executive Director

NOTICE OF RIGHT TO REQUEST REVIEW OR REHEARING

Any party may request a rehearing or review of this matter pursuant to A.R.S. § 41-1092.09. The motion for rehearing or review must be filed with the Arizona Board of

Osteopathic Examiners within thirty (30) days. If a party files a motion for review or rehearing, that motion must be based on at least one of the eight grounds for review or rehearing that are allowed under A.A.C. R4-22-106(D). Failure to file a motion for rehearing or review within 30 days has the effect of prohibiting judicial review of the Board's decision. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Original "Findings of Fact, Conclusions of Law and Order for Administrative Warning" filed this 7th day of February, 2017 with:

Arizona Board of Osteopathic Examiners
In Medicine and Surgery
9535 East Doubletree Ranch Road
Scottsdale AZ 85258-5539

Copy of the "Finding of Fact, Conclusions of Law and Order for Administrative Warning " sent by certified mail, return receipt requested, this 7th day of February, 2017 to:

Kenneth Gregory, Esq.
Gregory and Elias, P.C.
3640 Highway 95, Ste. 140
Bullhead City, AZ 86442

Copies of this "Findings of Fact, Conclusions of Law and Order for Administrative Warning" filed/sent this 7th day of February, 2017 to:

Teresa Borchers, D.O.
Address of record

AND

Jeanne Galvin, AAG
Mary DeLaat Williams, AAG
Office of the Attorney General SGD/LES
1275 West Washington
Phoenix AZ 85007